2015

City of Detroit
Active Employee
Benefits

MEDICAL | DENTAL | VISION | LIFE INSURANCE
FLEXIBLE SPENDING ACCOUNTS

To All City of Detroit Employees

In addition to providing a comparison of benefits that will assist you in determining which health care plans best meet the needs of you and your family, the City of Detroit Employee Health Care Plan Options booklet contains general eligibility rules for enrollment in medical, dental, vision, flexible spending, and life insurance plans offered by the City.

This booklet is designed for the new employee who may be enrolling in City health care and life insurance plans for the first time; the current employee who wishes to switch to a different health care plan or change his/her life insurance coverage during an open enrollment period; and for any employee who experiences a qualified life event that necessitates a change to his/her dependent's coverage outside of the open enrollment period.

This booklet also provides instructions on what you need to do to add coverage for an eligible dependent in the event you should marry, have or adopt a child or need to terminate coverage for a dependent due to death or for a dependent that becomes ineligible during the coverage year because of a divorce, age requirements, coverage from another source, or other reasons. It also explains what you must do to protect your health care coverage and life insurance in the event you are on an approved leave of absence, workers' compensation, or temporarily off the active payroll for 30 or more days for other reasons. It provides important information pertaining to you and your covered dependent's rights to continue coverage under COBRA in the event of the loss of your employment. It specifies the required time limits and the type of documentation required for enrollment and to continue coverage in response to the annual family continuation verification audits for dependent children age 26 or older, and much more.

It is important that you read this booklet in its entirety and that you keep it with your other important papers so that you can reference it as needed throughout the year.

The City of Detroit Employee Health Care Plan Options booklet is intended to be an easy-to-read summary guide for City employees. **It is not a contract.** The statements contained in this booklet regarding eligibility for coverage apply generally to all City employees. However, these statements are not intended to replace or supersede any City Code provisions, City Council resolutions or language in labor agreements governing health care or life insurance benefits.

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Glossary of Important Terms

Types of Medical Care Plans

Health Maintenance Organization (HMO)

HMO plans manage and coordinate your medical care. You must select a primary care physician from the HMO's provider directory who will provide the majority of your medical services and coordinate other services such as specialty care, hospital services, and diagnostic testing. Because you are required to use network providers, out-of-pocket expenses for covered benefits are usually lower than with other types of plans. It is important to note that employees who select an HMO plan must reside in the network service area of the HMO plan, six months of the year. If you move outside of the service area, you are no longer eligible for the HMO plan and must switch to another plan. Annual deductibles and copays are required for certain services.

Preferred Provider Option (PPO)

PPO plans consist of a network of independent physicians, hospitals and other health care providers who have agreed to accept a pre-approved amount as full payment for services provided to employees and members. Under this arrangement, your out-of-pocket expenses usually will be lower for covered benefits if you use network health care providers rather than out-of-network providers. Annual deductibles and copays are required for certain services.

Flexible Spending Accounts

A Flexible Spending Account (FSA) enables you to set aside money on a pre-tax basis to pay for your out-of-pocket health and day care costs. There are three components to your plan:

- Health Care FSA reimburses out-of-pocket health care expenses for you and your tax dependents.
- Day Care FSA reimburses day care expenses for your dependent child or elder care expenses.
- Commuter Benefits allows you to pay for public transportation or parking expenses on a pre-tax basis. The ***Flexi-Pass*** program is a consolidated commuter benefits platform where you can order a proprietary benefits card that is loaded with an amount of funds that you elect to be deducted from your paycheck for your transit and/or parking needs. The online ordering platform offers users a flexible, tax-free approach to commuter benefits. You must have an email account to access to this benefit. If you do not have an email account there are many websites where you can establish a free account such as gmail.com, yahoo.com, etc.

What You Should Do

- **Review** this booklet to familiarize yourself with the two health care plan options and the other benefits that are available. This includes:
  - Medical
  - Dental
  - Vision
  - Pre-tax Flexible Spending Accounts
  - Life Insurance
- **Determine** which health care plans best meet your needs and the needs of your eligible family members. If you have a spouse, it is a good idea to review your plan choices together and discuss the health care needs of any dependent children.
- **Call** the Benefits Administration Customer Service Line toll-free at 1-855-224-6200 **on or after November 10** if you have questions about this booklet.

  Representatives will take calls from 8:30 a.m. – 7:00 p.m. EST Monday – Friday.
- **If you prefer, you can email** the Benefits Administration Customer Service Center at help@mybenefitexpress.com
- **Call** a health care plan directly if you would like more specific information about their health care providers, facilities or services. The telephone numbers (and websites) are listed on the back cover of this booklet.
- **Sign up** for your benefit selections using the **Enrollment Process** described on page 7.
- **Choose Carefully.** Once you have chosen your benefit plan option for 2015, you will not be able to change to other benefit plan options or make changes to your benefit plan options until the next open enrollment period.

Eligibility for Health Care Benefits

Employee

Full-time and certain seasonal employees are eligible for enrollment in medical, dental, vision, flexible spending accounts, and life insurance plans. An employee enrolled in the plan is the subscriber or contract holder. The employee shall remit any required employee contributions (based on the plan selected) and payments for additional dependent coverage to the City through weekly, biweekly or monthly payroll deductions.

Note: The employee must notify the Benefits Administration Customer Service Line at 1-855-224-6200 or **www.mydetroitbenefits.com** of any change in health care coverage affecting the employee or any of his or her dependents. The employee must contact the payroll department to report any change of address.

Spouse

The legal spouse of an employee is eligible for dependent medical, dental, vision and life insurance coverage. Required documentation is a Marriage Certificate that has been properly filed in the County Clerk's office. (A Marriage License will not be accepted as sufficient documentation.)

Divorced Spouses

Divorced spouses are not eligible to be continued as dependents on the City's benefit plans even if the divorce decree mandates that coverage be provided. They may be eligible to purchase health care insurance under COBRA guidelines. Under these guidelines, the divorced spouse may qualify to keep the group health plan benefits for a set period of time. Individuals subject to COBRA coverage may be responsible for paying all costs related to premiums and deductibles. The ex-spouse's coverage as a dependent terminates as of the date the divorce decree is issued.

Spouses with Other Available Coverage

For employees whose spouses have hospitalization-medical coverage available under a plan offered by his/her employer other than the City of Detroit, said spouse must enroll in their employer's hospitalization-medical plan in order for the spouse to be eligible for coverage through the City of Detroit. In such cases, if you also enroll your spouse in the City health care plan as described in this booklet, the City's benefit plans will be the secondary insurer/payer.

Dependent Children 19 or younger

Natural and adopted children, stepchildren and children who are under legal guardianship, who are dependents of the employee, are eligible for dependent coverage (medical, dental, vision and life insurance) up to the end of the calendar year in which they reach age 19.

Required documentation for dependent children is a Birth Certificate or an order or ruling by a court. (For a newborn infant, a Verification of Birth naming the employee as a parent will initially be accepted, but the birth certificate must be presented within 90 calendar days.) Other documents or proof may also be required.

Dependent children from 19 to 26 years of age

Dependent children from 19 to 26 years of age are eligible for continued dependent medical coverage. Dependent eligibility will no longer be limited by financial dependency, marital status or enrollment in school.

Dependents from 19 to 25 years of age must be full-time students and meet the IRS definition of dependent, to continue to be eligible for dental coverage. Documentation may be required to prove eligibility.

Dependents over the age of 19 are not eligible for vision coverage.

Disabled Dependent Children

Totally and permanently disabled children may be covered to any age provided the disability was medically certified and the employee has submitted the required medical documentation and application for continued coverage (Form No. PA 275) to the Benefits Administration Office BEFORE December 31st of the year in which the dependent became 26 years of age. Failure to meet these requirements will result in disqualification for coverage as a disabled child.

Note: Your dependents are only entitled to City health care and life insurance coverage if they meet the eligibility requirements and you have submitted a request online at **www.mydetroitbenefits.com**. You must request to add them to your medical, dental, vision and/or life insurance contracts. The appropriate documentation and form(s) must be received by the Benefits Administration Office within the appropriate time period.

Coordination of Benefits

If you or a covered family member are entitled to benefits from a source other than your City of Detroit's health plan, such as a spouse's health insurance coverage or Medicare, Medicaid, coordination of benefits will take place. You are required to disclose information about any other source of benefits to the Benefits Administration Office.

In order to be eligible for coverage under all City of Detroit's health care plans, employees and covered family members who are eligible for Medicare due to End Stage-Renal Disease (permanent kidney failure) must enroll in Medicare Parts A and B. The medical conditions for required enrollment in Medicare are based on the Center for Medicare and Medicaid Services coordination of benefit rules which determine the conditions under which Medicare will be the primary payer for persons covered by employer group insurance. Such enrollment in Medicare shall not result in any reduction in benefits or additional cost to the employee, in that the employee shall be reimbursed the amount paid for Medicare after submission of required proof of enrollment and monthly payments.

IMPORTANT NOTE — CITY RETIREES MARRIED TO ACTIVE CITY EMPLOYEES: Retirees of the City are only eligible for the City's retiree health care options. An active employee may not enroll his or her City of Detroit retired spouse in his or her active employee health care coverage. All retirees of the City are only eligible for coverage under the City of Detroit's retiree health care program.

NO DUPLICATE MEDICAL COVERAGE

If the City employs more than one member of a family, or the family unit includes a retiree of the City, the spouse and eligible dependents of that family shall only be covered by one City employee – no duplicate coverage will be permitted. Furthermore, a retiree of the City may not be enrolled as a spouse of an active employee. A retiree only will receive retiree health coverage. It is the responsibility of the family to select a single health plan. Under no circumstances shall the City be obligated to provide more than one health policy or plan, or duplicate coverage for any employee or dependent.

IMPORTANT: Open Enrollment Process

- If you make no change to your medical, dental or vision coverage, you will be defaulted to your current coverage and charged the premiums associated with that coverage. Your current coverage for life insurance coverage, Flexible Spending Account, commuter plan, or medical opt-out credit will NOT automatically continue for 2015. You must complete the enrollment process if you choose to maintain these benefits for 2015. Carefully review the chart of plan defaults on page 8.
- ALL EMPLOYEES MUST LOG INTO **WWW.MYDETROITBENEFITS.COM** TO SELECT A LIFE INSURANCE BENEFICIARY DURING THE OPEN ENROLLMENT PERIOD.
- Open enrollment is scheduled to begin on November 10, 2014.
- You will be able to select your benefit plan options, add or delete dependents or report other changes affecting your coverage.
- When open enrollment begins, visit **www.mydetroitbenefits.com** to complete your enrollment online or call toll-free 855-224-6200 to speak to a representative to complete your enrollment over the phone.

  Your initial website log-in is:

  DET + first 5 characters of your last name + the last 4 digits of your SSN

  Your password is:
  Full date of birth in the format MMDDYYYY.

  Example:

  Name: William Johnson
  Date of Birth: 12/01/1964,
  Last 4 digits of your SSN: 6789

  Log-in: **DETjohns6789**

  Password: **12011964**

  If you previously created a password, it has been reset. You will need to create a new password.

  When you first log into the system, you will be immediately prompted to create your own unique password, which will be case-sensitive.

  Review your benefit plan elections carefully. Upon completing the enrollment process, you will be able to print a confirmation statement showing all of your elections. A copy of your confirmation statement will remain on the site for you to access at any time.

What happens if I do not complete the enrollment process?

If you do not complete the mandatory enrollment process and;

a) you are currently enrolled in medical, dental, or vision coverage, your current coverage will continue for 2015. If your spouse and/or dependent children are currently enrolled in your medical, dental or vision coverage, their current coverage will continue for 2015. Please see the chart below for the 2015 plan defaults.

b) you are a Police and Fire employee and you would like to keep the $5,000 per life insurance benefit for your dependent for 2015, you must complete the enrollment process to select this coverage.

c) you are enrolled in the Health Care or Dependent Care Flexible Spending Account or Commuter Plan. You must re-elect your contribution for 2015. If you make no election during the Open Enrollment period, you will be defaulted to an election of $0.

d) if you receive the medical opt-out credit and would like to continue to receive it in 2015, you must log in to select this coverage and complete the form.

Current 2014 Plan	2015 Plan	2015 Coverage
Blue Cross Blue Shield Community Blue PPO	Blue Cross Blue Shield Community Blue PPO	Same as 2014
HAP HMO	HAP HMO	Same as 2014
BCBS Dental	BCBS Dental	Same as 2014
Heritage Vision	Heritage Vision	Same as 2014
Basic Employee Life Insurance	Basic Employee Life Insurance	Same as 2014
Optional Employee Life Insurance	Optional Employee Life Insurance	Same as 2014
Optional Dependent Life Insurance	Optional Dependent Life Insurance	Same as 2014
Health Care Flexible Spending Account	None	None
Dependent Care Flexible Spending Account	None	None
Commuter Plan	None	None
Medical Opt-Out Credit	None	None
No Coverage	No Coverage	Same as 2014

ALL EMPLOYEES MUST SELECT A LIFE INSURANCE BENEFICIARY DURING THE OPEN ENROLLMENT PERIOD.

Vision coverage is a two year election. You may not enroll in or make changes to your vision coverage during 2015 enrollment.

Flexible Spending Accounts

TAXES 101

The federal government takes about 30% of each dollar that you earn in FICA and Federal Income Tax (FIT), and you take home the remaining 70% to use for your living expenses. If you live in the State of Michigan, there is an additional State Income Tax (SIT) of 4.5% paid to the State.

With a Flexible Spending Account (FSA) you can set aside money from your paycheck to pay for medical, day care, and commuter expenses before the Federal and State governments take their respective shares (between 30-35%).

ANNUAL ENROLLMENT REQUIRED

IRS regulations require that you enroll in the FSA benefit each year during open enrollment. If you want to participate in a FSA benefit for the 2015 plan year, you will need to make that election during the open enrollment.

HOW DOES IT WORK?

During open enrollment estimate your eligible expenses for each FSA plan year and enroll in a FSA for that amount. (See page 12 for eligible expenses). Keep in mind the following:

- Your election amount is deducted evenly from your paycheck throughout the plan year. These are pre-tax deductions, so you don't pay FICA (7.65%), Federal Income Tax (10-35%) or State Income Tax (4.25%) on your contributions.
- You cannot change your election after the plan year starts unless you experience a Qualifying Event. Common qualifying events include birth, death, adoption, marriage or divorce. Your election change must be consistent with the qualifying event.
- You must claim all elected funds by March 31, 2016. Money left in the plan after this date cannot be refunded to you; this is referred to as the Use-it or Lose-it rule.

HOW DO I GET REIMBURSED?

- The City of Detroit has contracted with Flex-Plan Services for FSA administration. Flex-Plan offers several convenient options on how to get a reimbursement from your plan. You can submit a traditional claim form through mail, email or fax. See Important Numbers on the last page of this booklet).

You must include documentation for your expense that shows the date of service, cost, and the type of expense you are claiming. Bills from your providers or statements from your insurance company are typically perfect forms of documentation. Do not submit copies of canceled checks, credit or debit card receipts.

Claims are generally processed within a few days of receipt of claim form and proper documentation, and reimbursements are issued on Mondays. You will receive additional information about the plan as part of your enrollment confirmation after your election has been processed.

ONLINE ACCOUNT ACCESS

As a participant, you will have online account access to view your FSA annual amounts and per pay deduction for through the **www.flex-plan.com** website. View your account balance, claims history, update your address, verify outstanding debit card charges and file your FSA claim online for faster claim processing. There is a link to the Flex-Plan website on the **mydetroitbenefits.com** home page.

HEALTH CARE FSA

If you expect to spend any money this year on health care expenses for yourself, your spouse and/or dependent children, you should consider participating in a Health Care FSA (HCFSA). The HCFSA is a pre-funded benefit. This means you have access to your full annual election amount at the beginning of the plan year and is available for use at any time during the plan year—regardless of how much you have contributed year to date.

The maximum annual election for the Health Care FSA is $2,500 per plan year.

TIPS FROM THE EXPERTS

Estimating future expenses is an important step as you prepare to enroll in a FSA. The more accurate you are in estimating your expenses, the better the plan will work for you. Here are some tips:

- Request a patient ledger from your pharmacy of your prior year's prescriptions.
- Request an annual statement from your insurance company.
- Think of any high-cost services like dental work, eye glasses, or surgeries that you have scheduled.

After you locate these documents, take into account that the HCFSA can also be used for your spouse and tax dependent(s), even if not covered by your employer's insurance plan.

Here's an example of the potential tax savings by enrolling in a HCFSA.

Health Care FSA Savings Example	Without HCFSA	With HCFSA
Gross Annual Salary	$36,000	$36,000
Pre-Tax Health Care Costs	-	$2,500
Taxable Income	$36,000	$33,500
Federal Income Tax (15%)	$5,400	$5,025
State Income Tax (4.25%)	$1,530	$1,424
FICA (7.65%)	$2,754	$2,563
After-tax Health Care Costs	$2,500	-
Net Annual Salary	$23,816	$24,488
Annual Savings	**-**	**$672**

Enrolling in the Health Care FSA would save the above employee over $670 per year in tax savings!

ELIGIBLE EXPENSES

A Health Care FSA covers a wide variety of expenses. We've assembled a list of common expenses that are eligible for reimbursement. Not all eligible items are on this list. For a more exhaustive list, visit the FPS website at **www.flex-plan.com**. ***Items marked with an asterisk (*) are considered over-the-counter (OTC) medicines or drugs and require a prescription for reimbursement.***

Acne treatment*
Acupuncture
Allergy & Sinus medication*
Antacids*
Antibiotic ointment*
Anti-diarrheal*
Antifungal foot cream*
Anti-gas medication*
Anti-itch cream/gel*
Antiseptic*
Asthma treatment*
Bandages/gauze
Birthing classes or Lamaze
Blood pressure monitor
Braces (knee, wrist, etc.)
Breast pump
Burn cream*
Chiropractic services
Coinsurance
Cold sore treatment*
Cold/cough medication*
Compression stockings
Contacts & solutions
Contraceptives
Copays
CPAP machine
Crutches
Deductibles
Dental services
Diabetic supplies
Diaper rash ointment*
Drug addiction treatment
Ear wax removal kits
Eye drops
Feminine Anti-Fungal/ Anti-Itch*
Fertility treatment
Flu shots
Hearing aids & supplies
Hemorrhoid medication*
Hormone therapy
Immunizations
Individual counseling
Lab work
Lactation Consultant
Lactose intolerance pills*
Laser eye surgery
Laxative*
Lice treatment products*
Motion sickness relief*
Naturopathic visits
Orthodontia
Orthotics
Oxygen and equipment
Pain relievers*
Parasitic treatment*
Physical exams
Physical therapy
Pregnancy test
Prenatal vitamins
Prescription drugs
Prescription glasses
Reading glasses
Saline nasal spray
Smoking cessation products*
Smoking cessation programs
Speech therapy
Sterilization procedures
Stool softener*
Thermometer
Throat lozenges*
Walker
Wart treatment*
Wheelchair & repair
X-rays

ADDITIONAL DOCUMENTATION REQUIRED

Certain medical expenses are not reimbursable under a Health Care FSA unless a licensed health care practitioner states that the service or product is medically necessary. Flex-Plan will need a Letter of Medical Necessity (LMN) for these items to be reimbursed; the LMN is available on **www.flex-plan.com**.

Please note that certain expenses may require additional documentation to be reimbursed.

INELIGIBLE HEALTH CARE EXPENSES

The following expenses are not eligible under a Health Care FSA. Under no circumstances will the following items be reimbursed. Please do not submit claims for these items.

Airborne
Books
Boutique practice fees
COBRA premiums
College insurance
CPR classes
Electrolysis/hair removal
Face lift
Finance charges
Funeral expenses
Gym membership
Household help
Hygiene products
Illegal operations
Imported OTC items
Imported prescriptions
Insurance premiums
Late fees
Liposuction
Marijuana
Marriage counseling
Massage chair
Missed appointment fee
Hair growth products
Electric toothbrush/picks
Teeth whitening
Toiletries
Veneers
Warranties

GRACE PERIOD

Your Health Care FSA plan offers a grace period allowing you to incur services for an additional 2 ½ months after your plan year is over (through March 15, 2016). Services incurred during this time frame will be first applied to your remaining balance from the 2015 plan year. All HCFSA services must be incurred on or before March 15, 2016 in order to apply to the January 1, 2015 - December 31, 2015 plan year.

CLAIM DEADLINES

The last day for submitting claims for health care expenses incurred from January 1, 2015 – March 15, 2016 is March 31, 2016. Any funds left in your Health Care FSA after March 31, 2016 are forfeited back to the City.

WHAT HAPPENS IF I TERMINATE EMPLOYMENT?

If you cease employment during the plan year, you have some options.

- STOP (default) – Your final paycheck will have the normal deduction and your participation will cease. You may be reimbursed only for services incurred on or before the termination date.
- ACCELERATE – You can authorize your employer to take the remaining FSA deductions from your final paycheck. This final deduction will be pre-tax and allows you to participate in the plan for the remainder of the plan year.
- COBRA – If your HCFSA balance is positive at the time of termination, then you will receive COBRA continuation paperwork to continue participation on a self-pay basis to the end of the FSA plan year.

ORTHODONTIA

Unlike other HCFSA expenses which are deemed incurred when the services are rendered, orthodontia expenses are deemed incurred when paid. Therefore, only payments made during your eligibility period and plan year may be reimbursed. Proof of payment to an orthodontic provider is required for reimbursement. Payments made toward orthodontia in a previous plan year or before your eligibility period are not reimbursable.

STOCKPILING

IRS regulations prohibit you from purchasing an unusually large quantity of any item in any one transaction. It would be reasonable if you purchased two or three of the same item, but anything over three items would be considered stockpiling and will not be reimbursed.

FSA DEBIT CARD

For Health Care FSA participants only, participants will receive a FSA Debit Card. This card works in the same manner as a debit card that you would get from your bank. The debit card is tied to your annual election amount. The FSA card can be used at authorized health care merchants to pay for FSA eligible services directly from your FSA balance. The card is accepted at participating merchants using the Inventory Information Approval System (IIAS) and at health care providers who accept MasterCard®. This includes:

- Doctor Offices
- Dental / Vision Clinics
- Hospitals
- Mail Order Rx Programs
- Pharmacy and Grocery Stores

DAY CARE FSA

Child care can be one of the single largest expenses for a family with children. A Day Care FSA (DCFSA) can be used to pay for your qualified day care expenses with pre-tax dollars. The provider can be a licensed day care facility or an individual. They must have a Social Security Number or Federal Tax ID number.

WHAT ARE THE RULES?

There are some rules to consider before enrolling in a DCFSA:

- A DCFSA works like a bank account. The reimbursement cannot exceed the account balance.
- The expense must enable you and your spouse to work, actively look for work, or be a full-time student. If your spouse is a full-time student, then your election is limited to $250 per month that they are a full-time student.
- Your dependent must live with you and must be 12 years old or younger. A dependent age 13 or older may be eligible if the dependent cannot physically or mentally care for his or her self.
- The day care provider cannot be a parent of the child, a dependent on your tax return or your child under the age of 19.

CALCULATING YOUR ELECTION

The DCFSA limit is set annually by the IRS. The maximum annual election for 2015 is $5,000 ***per household***. For example, if your spouse is already enrolled for $2,000 in the DCFSA for 2015 through his/her employer, then your maximum election through the City cannot exceed $3,000 for 2015.

Day Care Expenses Estimation Worksheet	
Before/After School Care	$
Elder Day Care	$
Pre-School	$
Day Care, including summer day camp fees	$
Annual Total	$

Some types of expenses are not eligible. These include tuition for school at the kindergarten level or above, overnight camp, nursing home expenses, meals, activity/supply fees and transportation costs. Montessori tuition for kindergarten and elementary school is not allowable; however, charges from a Montessori school for preschool or before and after school care are allowable.

FSA OR CHILD CARE TAX CREDIT?

Wondering if a DCFSA is better for you than the child care tax credit? Visit the Participant page on the Flex-Plan Services website at **www.flex-plan.com** and click the link "Tax savings calculator" to use an interactive tax calculator (Password: purple81). The tax calculator will give you an estimated savings comparison between the Child Care Tax Credit and participating in a DCFSA.

Note: Whether you choose to participate in the DCFSA or take the child care tax credit, you must file Form 2441 with your taxes.

CHANGES

Similar to other benefits, you can only change your election if you experience a Qualifying Event. However, in addition to the normal list of qualifying events, there are some special events exclusive to the DCFSA:

- A change in your day care costs, such as a rate decrease or increase, or receiving free day care.
- A change in your need for day care (your spouse loses employment or has a change in work schedule).
- Your dependent ceases to satisfy the eligibility requirements (example: Your dependent reaches 12 years of age).

GRACE PERIOD

Your Day Care FSA plan offers a grace period allowing you to incur services for an additional 2 ½ months after your plan year is over (through March 15, 2016). Services incurred during this time frame will be first applied to your remaining balance from the 2015 plan year. All DCFSA services must be incurred on or before March 15, 2016 in order to apply to the January 1, 2015 - December 31, 2015 plan year.

CLAIM DEADLINES

The last day for submitting claims for day care expenses incurred from January 1, 2015 – March 15, 2016 is March 31, 2016. Any funds left in your Day Care FSA after March 31, 2016 are forfeited back to the City.

WHAT HAPPENS IF I TERMINATE EMPLOYMENT?

If you terminate employment during the plan year, you can still access the funds in your DCFSA through the end of the plan year (even if the dates of service are after your termination date), as long as the expenses for care allow you to look for work or work full-time. However, you must submit your claims before the 90-day claim filing period that begins after your termination date.

DAY CARE FSA – ALLOWABLE EXPENSES

Keep in mind that day care expenses must be for children 12 or younger, unless the child is incapable of self-care.

Au Pair: The costs relating to an au pair for the care of a child are reimbursable.

Baby-sitter: As long as the sitter is not a dependent of the participant, or a spouse, the costs are eligible.

Before and after school care

Day Camp: If not overnight. Only the cost for the child to attend the camp is eligible.

Childcare by a relative: Cannot be a dependent of the plan holder. Must be at least 18.

Deposits: As long as the deposit is for daycare services that will be provided within the plan year the claim is being filed; and the service has been provided. Prorating may be necessary for those services that extend from one year to another.

Elder Care: Costs relating to the care of a dependent adult who is unable to care for themselves will qualify only if: 1) such expenses are not attributable to medical services; 2) the elderly person is a qualifying individual; and 3) in the case of services provided outside the employee's household the person still regularly spends at least eight hours each day in the employee's home. Elder day care will often qualify, but 24 hour care in a nursing home will not. We will need a Letter of Medical Necessity.

Care of Child Incapable of self-care: Children 13 and over incapable of self-care will be subject to restrictions as listed above under Elder Care (must spend at least eight hours a day in the home etc.). However, qualifying children under the age of 13 incapable of self-care do not need to spend at least eight hours a day in the employee's home. However, expenses for such children would still have to meet other requirements that could be affected by the amount of time they spend away from home. Please check with your tax advisor or IRS publication 501 and 503. We will need a Letter of Medical Necessity for any child 13 and over.

Extended Day Programs: Activities provided after school, which are primarily custodial in nature.

FICA and FUTA taxes: Paid to a daycare provider are eligible.

Nanny Fees: Costs relating to the payment of a nanny for the care of a child are reimbursable.

Nursery School/Pre-School/Pre-Kindergarten

Registration Fees: As long as the registration fee is for daycare services that will be provided within the plan year the claim is being filed; and the service has been provided. Prorating may be necessary for those services that extend from one year to another

Sick-child care: Only if they are enabling the parent to go to work.

COMMUTER BENEFIT

HOW DOES IT WORK?

A Commuter Benefit Flexible Spending Account allows you to use pre-tax contributions to pay for eligible parking/transit expenses. The Commuter Benefit, also know as Flexi-Pass Program, administered by Flex-Plan Services, allows you to pay for work related travel and parking costs with pre-tax dollars. Pre-tax means no federal income tax or FICA tax. The funds you allocate for your transportation and parking needs will be loaded onto a special debit card. You can then use your card to purchase services at any transportation or parking facility that accepts MasterCard™.*

If you already have a debit card from Flex Plan Services, your transit and/or parking funds will be loaded to your current card—there's no need to wait for a new one. If you don't have a card, you will receive one once you submit your first order.

*In the event your merchant does not accept the debit card, you may be able to utilize the Pay Me Directly option. Go to **www.mydetroitbenefits.com** for a link to find more information on the commuter benefit.

Telephone Calls to the Benefits Administration Customer Service Line:

If you have questions or concerns regarding your health care or life insurance coverage, please contact the Benefits Administration Customer Service Line at **1-855-224-6200**. When you call, you will be asked specific questions to verify that we are speaking directly to the employee and contract holder for the City of Detroit health care and life insurance plans. This security procedure is in accordance with the City of Detroit policies and is in place to protect your privacy.

Important Notice

Patient Protection and Affordable Care Act

The newly enacted federal health reform laws provided under the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act, require that the employer provide you with certain notices. These important notices are found on the next page.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find and acquire health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins on November 15, 2014 and runs through February 15, 2015.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if the coverage offered by the City and described in this booklet doesn't meet certain standards. The savings on your premium for insurance that you acquire on the Marketplace depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If the health coverage that the City offers you and is described in this booklet meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing, if the coverage that the City offers and which is described in this booklet would cost you more than 9.5% of your household income for the year, or if the coverage the City provides does not meet the "minimum value" standard set by the Affordable Care Act.[1]

Note: If you purchase a health plan through the Marketplace instead of enrolling in and accepting health coverage offered by the City, then you will lose the amount that the City pays toward the cost of its employer-offered coverage. Also, the amount that the City pays toward the cost of the coverage described in this booklet — as well as your employee contribution to such employer-offered coverage — is excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

Does Coverage Provided by the City Meet the Minimum Value Standard? Is the Coverage Provided by the City Affordable?

Coverage provided by the City meets the minimum value standard and the cost of the coverage to you is intended to be affordable, based on the wages paid to most active City employees. However, depending on your particular wages and household income, you may still be eligible for a premium discount for a health care plan you purchase through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Women's Health Initiatives

As mandated by the federal Patient Protection and Affordable Care Act (PPACA), Blue Cross Blue Shield of Michigan and Health Alliance Plan are covering some additional preventive services for women with no cost-sharing (copay/deductible/coinsurance) when administered by a network provider during a visit with preventive care as the primary reason for the appointment. Out-of-pocket costs, such as deductibles, copays and coinsurance, will still apply if services are provided to reach a diagnosis, monitor or treat an illness, injury or health problem. These services may have additional restrictions. Employees/dependents are encouraged to call the Customer Service number at BCBSM or HAP for more specific information.

Under the CVS Caremark prescription drug plan or the HAP prescription drug plan, some contraceptives may still require cost-sharing. Only those contraceptive services and contraceptive drugs that are performed or provided by a medical provider or require a doctor's prescription will be covered with no cost-sharing. Over the counter contraceptives such as condoms and foams that do not require a prescription will not be covered. Male sterilization may require cost-sharing if covered under the member's plan.

The City encourages employees/dependents to contact BCBSM, HAP, or CVS Caremark Customer Service for more specific information before incurring an expense to ensure you understand the benefits available at no cost to you.

Summary of Benefits and Coverage

As part of the federal Affordable Care Act, health carriers and group health plans are now required to provide current and prospective members with a Summary of Benefits and Coverage (SBC). The SBC must include Coverage Examples which are intended to show how the plan might cover medical care in a given situation. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. It is important to note that the SBC is not a contract. For a complete description of benefits and terms of coverage, consult the applicable BCBSM or HAP plan documents. A stand-alone, standard glossary of medical and insurance terms must also be provided. Please note these are federal agency definitions and do not necessarily reflect BCBSM or HAP definitions of the same terms. You may obtain a copy of the SBC and Uniform Glossary Document from the Benefits Administration Office or at **www.mydetroitbenefits.com**.

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Notice of Patient Protections

The City of Detroit's HMO option allows the designation of a primary care provider. Individuals have the right to designate any primary care provider who participates in the HAP network and who is available to accept you or your family members. Individuals do not need prior authorization from the City's medical plan providers or from any other person in order to obtain access to obstetrical or gynecological care. For children, individuals may designate a pediatrician as the primary care provider. The health care plan professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. For a listing of participating health care providers, please contact HAP at the customer service numbers provided in this booklet or call the number on the back of your medical plan identification card or visit the carrier's website. The carrier information is listed on the back cover of this booklet.

Notice of Health Care Dependent Audits

The City of Detroit may conduct eligibility audits at any time for any dependent that is covered under City insurance plans. If you receive a notice of audit, you must provide the documentation within the time period specified in the notice or the coverage for your dependent will be terminated. If you recently added or provided documentation for that dependent, you are still obligated to comply with the audit requirements and submit this documentation again. Failure to provide documentation that substantiates the eligibility of any dependent will result in termination of the dependent's medical, dental, vision and life insurance coverage. If the coverage is terminated, your dependent cannot be reinstated until the next open enrollment period (usually offered in the fall of the year, with a January 1st or later effective date). If you apply to reinstate the dependent's coverage during open enrollment, you will be required to provide required documentation in respect to the dependent.

Coverage Effective Dates

Requests for enrollment in the City's medical, dental, vision and life insurance for new hires, persons returning from a leave of absence, and persons recalled from layoff are due within thirty (30) calendar days of the date of hire or return to work. New hires are generally eligible for medical and flexible spending account coverage after you complete 90 days of employment. New hires become eligible for dental and vision coverage after you complete 6 months of employment. Special rules may apply to employees returning to active employment.

Open Enrollment: A designated open enrollment period is generally scheduled each year for medical, dental, flexible spending accounts and life insurance plans, and every other year for vision plans. Unless otherwise posted, changes in health care and life insurance coverage made during the Open Enrollment period will become effective the first of the month after open enrollment ends.

Mid-Year Enrollments: Any requests during the year for additions of dependents (e.g., marriage or birth of a child) must be completed online at **www.mydetroitbenefits.com** within thirty (30) calendar days of the life event. You may also call the Customer Service Center at 1-855-224-6200. Coverage will be made retroactive to the date of the event after online enrollment has been completed and required documentation has been provided to Benefits Administration Office. If the online enrollment is not completed within the thirty (30) calendar day period, the employee must wait until the next Open Enrollment period to add the dependent to his or her medical, dental, vision, flexible spending accounts and/or life insurance coverage.

Coverage Terminations

Employees are responsible for notifying the City of any event that makes a dependent ineligible for continued health care coverage. You must go online to **www.mydetroitbenefits.com** to make this change. There are specific rules governing termination dates in cases of divorce and death. The coverage termination date for an ex-spouse is the date of the divorce decree, and for the deceased it is the date of death. In other cases, the general rule is that the termination of coverage becomes effective on the last day of the month in which the disqualifying event occurs. To stop applicable payroll deductions and avoid personal liability for health care provided after the effective termination date, the employee must take action promptly to remove the ineligible dependent from his or her medical, dental, vision and life insurance contract(s) within thirty (30) days following the disqualifying event. Once a dependent is terminated from coverage, the employee must wait until the next Open Enrollment period to add the dependent to his or her medical, dental, vision and/or life insurance coverage.

Disqualifying Events: Events that can make a dependent ineligible include, but are not limited to, marriage, divorce, and age. The employee is also required to report the death of a dependent and to provide a copy of the death certificate. In order to remove a spouse from your coverage due to divorce or legal separation, you must provide a copy of the divorce decree or separation agreement. To ensure that the former dependent is removed from the employee's medical, dental, vision and life insurance contracts, you must go online to **www.mydetroitbenefits.com** and make this change. In addition, you must submit the appropriate documentation to the Benefits Administration Office within thirty (30) days following the disqualifying event.

Protecting Benefits While on Unpaid Leaves

When you are off the active payroll (i.e., have exhausted all sick leave, vacation, "c-time") and are placed on an approved unpaid Family and Medical Leave (FMLA), Workers' Compensation, Long Term Disability or City Leave of Absence for health reasons, and you wish to continue medical, dental, vision, flexible spending accounts, and/or life and death benefits, you must contact the Benefits Administration Office to determine eligibility, complete the necessary forms and make arrangements to pay for such continued benefits. The amount you will be required to pay to continue coverage for these benefits will depend on the plan(s), the number of dependents covered and the type of unpaid leave for which you are approved. (For example, an employee placed on an approved FMLA is required to pay the employee cost sharing contribution amount that would be deducted from his/her payroll check if he/she were on the active payroll. However, those on an approved Leave of Absence are required to pay the full premium amount (100% of the cost for the benefit)). These payments must be made monthly via money order or certified check, and must be received in full at the Benefits Administration Office by the due date. Failure to notify the Benefits Administration Office to make arrangements for continued coverage, complete the required forms, or make full and timely payments will result in a lapse of coverage or termination of benefits for the employee and his/her dependents. In such cases, neither the City nor the insurance carrier will be responsible for any claims filed, including but not limited to prescription drug coverage and medical and life insurances. If your health care benefits or life insurance are terminated while you are off the active payroll, you must complete the health care and life insurance enrollment online at **www.mydetroitbenefits.com** and submit any necessary documentation to the Benefits Administration Office immediately upon your return to reactivate your health care benefits.

Monitoring Payroll Deductions

Neither you nor the City should continue paying for medical, dental, vision and/or life insurance that you no longer require or for dependents that are no longer eligible for coverage. You, as the employee are responsible for providing notification to terminate the coverage for your dependents that are no longer eligible for benefits. You can provide notification to terminate online at **www.mydetroitbenefits.com**. You, as the employee, have a responsibility to periodically review your dependent coverage and to timely submit the necessary form to immediately terminate coverage for ineligible dependents. You will be financially responsible for all claims and premiums paid by the City of Detroit for any dependents enrolled in your health care and life insurance plans who do not meet the eligibility requirements. You are also responsible for confirming your paycheck stubs each pay period to verify that the proper amount of money for your payroll deductions for medical, dental, vision, flexible spending account, and life insurance are being deducted from your pay. Your payroll deduction for medical insurance is listed on your paycheck stub next to the word "Hospital." If an incorrect amount is being deducted, you must immediately report these errors to the Benefits Administration Office. You may contact the Benefits Administration Office to report changes in dependent coverage either on-line **www.mydetroitbenefits.com** or by telephone 1-855-224-6200.

Proper Notification

The City is not responsible for any excess contributions made because the employee failed to provide proper notification of ineligibility of a dependent. This notification of ineligibility for health care and life insurance benefits must be submitted online at **www.mydetroitbenefits.com** or via phone at 1-855-224-6200 within 30 calendar days of the disqualifying event. Failure to do so can subject you to discipline up to and including discharge. Also, you WILL be responsible for expenses incurred as a result of continued coverage after the disqualifying event. You are urged to keep a copy of all City of Detroit health care documents.

Providing False Information

Employees, who submit false information to provide health care and life insurance coverage for alleged dependents not eligible for such coverage may be subject to discipline up to and including discharge. Such employee will also be held financially responsible for all claims filed, and will be required to reimburse the City for any payments made on behalf of or for the benefit of an ineligible person claimed as a dependent.

Notification of Address Change

We must have your correct address to send you information regarding your benefits. It is your responsibility to provide notification of any address change to the payroll department. Failure on your part to do so may result in delayed notification, excessive out-of-pocket expenses or loss of continued coverage opportunity. You should also monitor your payroll check to verify that your address is correct. If there is a discrepancy, provide notification to the payroll department.

A Check List of Important Items to Remember

Employees must provide notification online at www.mydetroitbenefits.com if…

- You get married or divorced
- Your dependents change (e.g., birth or adoption of child)
- Your spouse or a dependent dies
- You, your spouse or a dependent becomes eligible for Medicare due to age or disability
- Note that you must provide documentation (marriage certificate, divorce decree, Medicare ID card) to the Benefits Administration Office either via fax or mail.

Contact the Benefits Administration Office if…

- You are laid off
- You are placed on an unpaid Family and Medical Leave, Workers' Compensation, Long Term Disability or City Leave of Absence
- You return to work after being off the active payroll for 30 or more calendar days
- You elected to participate in the City's Opt-Out program and you lose your other medical coverage for a reason that you did not cause, or could not prevent
- Be sure to include your Social Security number in all communications to the Benefits Administration Office.

You must contact the health care provider if…

- You have questions regarding services and expenses covered under the health care plan you selected
- You have questions regarding a bill you received for services
- You wish to verify providers that are available under the plan you selected

You must contact your local Social Security Office if...

- You have questions regarding Social Security or Medicare
- You or one of your dependents has a severe long-term disability, end-stage renal disease, or is undergoing a kidney transplant because you may be eligible for Medicare coverage prior to age 65. If you or one of your dependents fits any of these categories, you should have your case evaluated by the Social Security Administration.

You must contact the Flexible Spending Account provider if….

- You have questions about your flexible spending account or eligible/ineligible services
- You need assistance to submit a claim for services
- You want to know if your claim has been processed.

Remember ...

To add your new dependents within 30 calendar days of a life event, such as marriage or the birth or adoption of a child. If you do not meet this mid-year enrollment deadline, you will not be able to add the new dependent until the next annual open enrollment period. (**Note:** You are required to submit the required documentation to substantiate the event and that the dependent is eligible for coverage).

To remove your ineligible dependents from your medical, dental, vision, and life insurance plans within 30 calendar days of the disqualifying event. If you fail to submit the required documentation to remove the ineligible dependent, you WILL be liable for expenses incurred as a result of his/her continued health care and/or life insurance coverage. You may also be subject to discipline up to and including discharge.

DIVORCE

If you should get a divorce, your ex-spouse and his/her dependent(s) have different coverage rights after the date of the divorce. Such ex-spouse will be eligible for COBRA continuation coverage. It is your responsibility to provide notification online at **www.mydetroitbenefits.com** and provide a copy of the divorce decree to the Benefits Administration Office. Although the City's required date to remove dependents is within 30 days of the disqualifying event, if you fail to remove these ineligible dependents from your contract within 60 days they may lose their rights under COBRA, and you WILL be liable for medical claims and/or premiums incurred from the date of the divorce, as well as subject to disciplinary action up to and including discharge.

DEADLINES

Deadlines for the open enrollment period, mid-year enrollment for life events and all eligibility audits are strictly enforced. If you fail to meet the required time limits you will have to wait until the next annual open enrollment period to add or reactivate the coverage for your dependent.

NOTICE OF COVERAGE TERMINATION

If you receive a Notice of Coverage Termination from the Benefits Administration Office or a health care provider, do not ignore it! It does not matter that you are on a Family and Medical Leave, Workers' Compensation, or off the active payroll for a temporary period of time for any reason, and believe your health care coverage should be continued. The Notice of Coverage Termination is official notification that your health care and life insurance coverage with the City of Detroit has been terminated and you are no longer insured. It is strongly recommended that you designate a trusted and responsible family member to monitor your mail and handle your business affairs when you are sick or otherwise incapacitated and unable to attend to such matters. This is important because the health care providers have strict rules regarding reinstating insurance after the coverage has been terminated. If you believe the Notice of Coverage Termination was sent to you in error, you must immediately contact the Benefits Administration Office at the telephone number or the on-line web site listed on the notice.

The same rule applies if you should receive a Notice of Coverage Termination for your dependent and you believe the notice was sent in error.

Dependent Enrollment Documentation At-A-Glance

What Documentation Must I Provide?	Dependent Classification & Eligible Plan		
Read the "*Eligibility for Health Care Benefits*" section of this booklet for additional information regarding dependent and benefit coverage eligibility. Also, some rules for eligibility and plan coverage may differ based on collective bargaining unit agreements.	**Legal Spouse**	**Dependent Child** (newborn up to day prior to 19th birthday)	**Dependent Continuation*** (age 19 up to day prior to 26th birthday)
If a "**yes**" appears in the dependent classification column you must provide the indicated documentation. Additional documentation may be required to substantiate enrollment eligibility and audits.	Medical, dental, vision and life	Medical, dental, vision and life	Medical, dental* and life*
Marriage Certificate **Note:** A Marriage License will not be accepted as sufficient documentation. (*IRS Tax Transcript may be required during dependent audits.*)	**Yes**	**No**	**No**
Birth Certificate Note: For a newborn infant, a Verification of Birth naming the employee as a parent will be initially accepted, but the birth certificate must be presented within 90 calendar days.	**No**	**Yes**	**Yes**
The original **IRS transcript** of your federal income tax return for the current year. Note: To obtain your federal Tax Return Transcript from the IRS, call **(800) 829-1040**, and follow the prompts in the recorded message. There is no charge for the transcript, and you should receive it within ten (10) business days from the time you make your request. We recommend that you order your transcript as soon as possible so that you will be able to provide the required documentation by the due date.	**No**	**No**	**Medical, Life – No** **Dental – Yes**
A copy of the dependent's **social security card**.	**Yes**	**Yes**	**Yes**
A copy of the dependent's **Medicare card**. Note: If the dependent is permanently disabled or age 65 and older and not eligible for Medicare, you must provide documentation from the Social Security Administration Office that the dependent is not eligible for Medicare.	**Yes**, if eligible for Medicare due to age or disability	**Yes**, if eligible for Medicare	**Yes**, if eligible for Medicare

*Dependent over the age of 25 are not eligible for dental or life insurance coverage. Dependents over the age of 19 are not eligible for vision insurance.

Please retain photo copies of all health care forms and documents submitted for your personal records.

Time Limits for Submission of Enrollment Information & Documentation are Strictly Enforced!

*Go online to **www.mydetroitbenefits.com** to make updates.*
Note that supporting documentation must be sent to the Benefits Administration Office.

New Hires: 30 calendar days from date of hire. **Life Events:** 30 calendar days from the life event. **Open Enrollment:** Designated Dates (examples of life events include marriage, birth of a child, loss of coverage for a reason that you did not cause, or could not prevent)
Notification that a child is totally and permanently disabled: Before December 31st of the year in which the child became 19.

Our Commitment Regarding Your Personal Protected Health Information

We understand the importance of your Personal Protected Health Information (hereafter referred to as "PHI") and follow strict policies (in accordance with state and federal privacy laws) to keep your PHI private. PHI is information about you, including demographic data, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health, the provision of health care to you or the payment for that care.

We must follow the privacy practices described in this notice while it is in effect. This notice is directed to recognize our responsibilities under the Health Insurance Portability and Accountability Act (HIPAA) which went into effect April 14, 2003, and will remain in effect until we replace or modify it consistent with provisions of the Act.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. These revised practices will apply to your PHI regardless of when it was created or received. Before we make a material change to our privacy practices, we will mail a revised notice to our benefit plan participants.

Where multiple state or federal laws protect the privacy of your PHI, we will follow the requirements that provide greatest privacy protection. For example, when you authorize disclosure to a third party, state law requires the City of Detroit to condition the disclosure on the recipient's promise to obtain your written permission to disclose to someone else.

If you have any questions regarding the City's policy on PHI, please go online to **www.mydetroitbenefits.com** or call the benefits administration customer service line toll-free at 1-855-224-6200 for more information.

SOCIAL SECURITY NUMBERS AND HEALTH INSURANCE CLAIM NUMBERS:

In order to properly administer coordination of benefits, you MUST provide the Social Security Numbers (SSN), and where applicable, the Health Insurance Claim Numbers (HICN), for all dependents covered under City of Detroit health care plans. Enrollment forms that do not contain this required information will not be processed.

Also the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers, third party administrators, and plan administrators to provide SSNs (or HICNs) to the Center for Medicare & Medicaid Services (CMS) in order for Medicare to properly coordinate Medicare payments. For further information on this mandatory reporting requirement under this law, please visit the CMS Web site at www.cms.hhs.gov/MandatoryInsRep

Please be assured that your SSN and HICN will only be used for the purpose of required reporting and coordination of benefits and that we will adhere to all privacy and confidentiality laws.

Notice of Right to Continue Health Care Benefits Under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), the City of Detroit is required to offer the opportunity for a temporary extension of health care coverage (called "Continuation Coverage") at group rates to former employees, spouses, and eligible dependents in certain instances where coverage under the City's plan(s) would otherwise end due to certain qualifying events. *This notice is intended to provide you and any covered dependents with a summary of your rights and obligations under the continuation coverage provisions of the law.*

Qualifying Events for Covered Employees – If you are an employee of the City of Detroit covered by our group benefit plans, you may have the right to choose continued coverage if you lose your group benefit coverage because of the termination of your employment (for reasons other than gross misconduct) or a reduction in your work hours.

Qualifying Events for Covered Spouses – If you are the spouse of an employee of the City of Detroit and are covered by our group benefit plans you may have the right to choose continuation coverage for yourself if you lose group benefit coverage under the plan for any of the following reasons: termination of your spouse's employment (for reasons other than gross misconduct); a reduction of your spouse's hours of employment; the death of your spouse; or divorce or legal separation from your spouse.

Qualifying Events for Covered Dependent Children – If you are the covered dependent child of an employee covered by our group benefit plans you may have the right to continuation coverage for yourself if group benefit coverage under the plan is lost for any of the following reasons: termination of the employee's employment (for reasons other than gross misconduct); a reduction in the employee's hours of employment; the death of the employee; the employee's divorce or legal separation; you no longer meet the eligibility requirements of a "dependent child" under the rules of the City of Detroit's health care plan.

NOTIFICATION INSTRUCTIONS

All notification requirements referred to in this summary must be made via the Benefits Administration Customer Service Line at **1-855-224-6200**
Service Center Hours: 8:30 a.m. – 7:00 p.m. Monday – Friday EST
or online at **www.mydetroitbenefits.com**.

Employee, Spouse, and Dependents Notifications Required – Under the law, the employee, spouse, or other family member has the responsibility to inform the City of Detroit – Benefits Administration Office of a divorce, legal separation, or a child losing dependent status under our group health care plan. This notification must be made within 30 days from the date of the event or the date, on which coverage would end, whichever is later. Visit **www.mydetroitbenefits.com** to report these changes. **Note:** Required documentation must be submitted to the Benefits Administration Office. *If this notification is NOT completed in a timely manner, rights to continue coverage may be forfeited.*

Election Period and Coverage – Once notification of a qualifying event has occurred, covered individuals (also referred to as qualified beneficiaries) will be notified of their right to elect continuation coverage. Each qualified beneficiary has independent election rights and will have 60 days from the date coverage is lost under the City's health care plan or the date of notification, whichever is later, to elect continuation coverage. *If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue insurance under the City's group health care plan will end.*

If a qualified beneficiary elects continuation coverage and pays the applicable premium, the City of Detroit is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the plan to similarly situated employees and/or covered dependents.

Length of Continuation Coverage – 18 months: If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction of work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event.

- **Social Security Disability** – The 18 months of continuation coverage can be extended to 29 months if the Social Security Administration determines that a qualified beneficiary was disabled at any time within the first 60 days of continuation coverage according to Title II or XVI of the Social Security Act. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and notify the City of Detroit – Benefits Administration Customer Service **855-224-6200** or **www.mydetroitbenefits.com** within 60 days of the date of determination and before the original 18 month period expires. It is also the qualified beneficiary's responsibility to notify within 30 days that a final determination has been made that they are no longer disabled.
- **Secondary Events** – An extension of the 18 months of continuation coverage can occur if, during the initial 18 months of continuation coverage, a second event takes place (divorce, legal separation, death, or a dependent child ceasing to be a dependent). If a second event does take place, then the 18 month of continuation coverage can be extended to 36 months from the date of the original qualifying event date for the qualified beneficiary spouse and/or dependent children. If a

second event occurs, it is the qualified beneficiary's responsibility to notify the City of Detroit – Benefits Administration Customer Service at **855-224-6200** or **www.mydetroitbenefits.com**. In no event, however, will continuation coverage last beyond three years from the date of the original qualifying event.

Length of Continuation Coverage – 36 Months: If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, or a dependent child ceasing to meet the eligibility requirements for coverage under the City of Detroit health care plan rules, each qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event.

Eligibility, Premiums, and Potential Conversion Rights – A qualified beneficiary does not have to show that he/she is insurable to elect continuation coverage. The City of Detroit, however, reserves the right to verify eligibility status and terminate continuation coverage retroactively if the person is determined to be ineligible or if there has been a material misrepresentation of the facts. A qualified beneficiary will have to pay all of the applicable premiums plus a 2% administration charge for continuation coverage. These premiums may be adjusted in the future if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, the City of Detroit can charge up to 150% of the applicable premium during the extended coverage period. There is a grace period of 30 days for the regularly scheduled monthly premiums. At the end of the 18 months or 36 months of continuation coverage, a qualified beneficiary must be allowed to enroll in a conversion plan.

Notification of Address Change – To insure that all covered individuals receive all required information, it is important that you immediately provide notification of any address change online at **www.mydetroitbenefits.com**

Cancellation of Continuation Coverage – The law provides that if elected and paid for, continuation coverage may end prior to the maximum continuation period for any of the following reasons:

1. The City of Detroit ceases to provide group health care coverage to all City of Detroit employees;
2. The total monthly cost for continuation coverage is not paid on a timely basis;
3. The qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation which does not apply to (or satisfied by) such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996;
4. A qualified beneficiary becomes eligible for Medicare;
5. A qualified beneficiary has extended coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
6. A qualified beneficiary notifies the City of Detroit – Benefits Customer Service 855-224-6200 that he/she wishes to cancel continuation coverage.

The qualified beneficiary is required to notify the City of Detroit – Benefits Administration Customer Service 855-224-6200 if event # 3, 4, 5, or 6 occurs. If continuation coverage is terminated for any of the above reasons, it cannot be reinstated.

Selecting Health Care Plans

On the following pages are informational exhibits of the medical, dental and vision plans available to City employees. There are also employee benefit summaries for each plan offered. These summaries may be useful in deciding which plans are best suited to your needs and the needs of your dependents.

The health care plan options described in this booklet provide protection against a wide range of health care expenses. While coverage is broad and comprehensive, plans vary in the benefits they offer, and will not cover all health care services and expenses under all circumstances. Therefore, contact your health care plan if you have questions as to whether or not a particular health care service or expense is covered and whenever possible obtain pre-approval before having services performed. Telephone numbers for each medical, dental and vision plan carriers are listed on the last page of this booklet.

Opt-Out Program

City employees who are covered under a medical care plan of an employer other than the City of Detroit (e.g., through a spouse or other relative), may choose not to enroll in the City's health care program, and instead receive a cash amount from the City. If the employee and his/her spouse are both employed by the City, no Opt-Out is available. City employees must elect Opt-Out participation annually to continue receiving any eligible payments.

Generally, the Opt-Out Program provides you with a cash payment of $950 annually. Most participants receive payments quarterly through regular payroll processes. Employees paid by the Oracle System are paid a stipend of $36.54 on their bi-weekly payroll check. All other employees are paid a stipend of $237.50 on the last payroll check in January, April, July and October of each year. More information on the Opt-Out program may be obtained by calling the Benefits Administration Customer Service Line at 1-855-224-6200 or online at **www.mydetroitbenefits.com**

Submission of an Opt-Out election application form and proof of other medical insurance coverage (not provided by the City of Detroit) is required to receive your Opt-Out payment. Current employees may exercise the Opt-Out option only during the Open Enrollment period. Employees who Opt-Out of the City's health care plan may continue to participate in the City's dental and vision plans.

Employee Medical Plan Design

	BCBSM Community Blue PPO		HAP
	In-Network	Out-of-Network	In-Network Only
Deductibles			
Annual Deductible	$750 Single $1,500 Family	$1,500 Single $3,000 Family	$750 Single $1,500 Family
Coinsurance			
Coinsurance	20% for select services	40% for all services except Emergency Room	20% for select services
Out-of-Pocket-Maximums (OOPM)			
Coinsurance OOPM	$1,500 Single $4,500 Family (Not including Deductible)	$3,000 Single $9,000 Family (Not including Deductible)	$1,500 Single $4,500 Family (Not including Deductible)
Medical and Prescription OOPM (Separate OOPM may apply for Medical and Prescription Drugs)	$6,350 Single $12,700 Family (including Deductible)	No Maximum	$6,350 Single $12,700 Family (including Deductible)
Physician Office Services			
Office Visits	$25 copay	Plan Pays 60% after Deductible	$25 Copay
Specialist Care	$25 copay	Plan Pays 60% after Deductible	$25 Copay
Preventive Services			
Health Maintenance Exam	Plan Pays 100%	Not Covered	Plan Pays 100%
Annual Gynecological Exam	Plan Pays 100%	Not Covered	Plan Pays 100%
Mammography Screening	Plan Pays 100%	Not Covered	Plan Pays 100%
Pap Smear Screening	Plan Pays 100%	Not Covered	Plan Pays 100%
Immunizations	Plan Pays 100%	Not Covered	Plan Pays 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Plan Pays 100%	Not Covered	Plan Pays 100%
Hospital Care			
Number of days of care	Unlimited Days	Unlimited Days	Unlimited Days
Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Plan Pays 80% after Deductible and $100 Copay	Plan Pays 60% after Deductible	Plan Pays 80% after Deductible and $100 Copay
Outpatient Surgery	Plan Pays 80% after Deductible and $100 Copay	Plan Pays 60% after Deductible	Plan Pays 80% after Deductible
Emergency Care			
Hospital Emergency Room (waive if admitted)	$100 Copay - Deductible does not apply (also waived if accidental injury)	$100 Copay - Deductible does not apply (also waived if accidental injury)	$100 Copay - Deductible does not apply
Urgent Care	$25 Copay - Deductible does not apply	Plan Pays 60% after Deductible	$25 Copay - Deductible does not apply
Ambulance - medically necessary	Plan Pays 80% after Deductible	Plan Pays 60% after Deductible	Plan Pays 80% after Deductible (emergency only)

This comparison chart describes the essential features of the above health plans in general terms. It is not intended to be a full description of coverage. All efforts have been made to correctly summarize the level of benefits, however, if an error has been made in the summary description, the Certificate of Coverage issued by the plan will supercede this document. The complete plans are described in the Certificate of Coverage issued by each plan, and are available on request to all interested persons.

Note: Out-of-Pocket Maximum and Co-Insurance may be applied to certain services.

Employee Medical Plan Design *continued*

	BCBSM Community Blue PPO		HAP
	In-Network	**Out-of-Network**	**In-Network Only**
Diagnostic Services			
Laboratory and pathology tests	Plan Pays 80% after Deductible	Plan Pays 60% after Deductible	Plan Pays 80% after Deductible
Diagnostic tests and X-rays	Plan Pays 80% after Deductible	Plan Pays 60% after Deductible	Plan Pays 80% after Deductible
Alternatives to Hospital Care			
Skilled Nursing Care in a nursing home	Plan Pays 80% after Deductible. Limited to a maximum of 120 days	Plan Pays 60% after Deductible. Limited to a maximum of 120 days	Plan Pays 80% after Deductible (up to 730 days; renew after 60)
Mental Health Care			
Inpatient mental health care	Plan Pays 80% after Deductible and $100 Copay	Plan Pays 60% after Deductible	Plan Pays 80% after Deductible and $100 Copay
Outpatient mental health care	$25 Copay - Deductible does not apply	Plan Pays 60% after Deductible	$25 Copay - Deductible does not apply
Appliances & Prosthetic Devices			
Prosthetics & Orthotics	Plan Pays 80% after deductible	Plan Pays 60% after deductible	Plan Pays 80% after Deductible for approved equipment
Durable Medical Equipment	Plan Pays 80% after deductible	Plan Pays 60% after deductible	Plan Pays 80% after Deductible for approved equipment
Chiropractic Services			
Chiropractic Care	$25 Copay - Deductible does not apply	Plan Pays 60% after deductible	Not Covered
Prescription Drugs – Prescription Drugs provided by CVS Caremark			**HAP**
Certain drugs require prior authorization and have quantity restrictions.			
Prescription Drug Deductible	None		None
Retail Generic (30 day)	$10 Copay		$10 Copay
Retail Formulary Drug – Brand Name (30 day)	$35 Copay		$35 Copay
Retail Formulary Drug – Non-Preferred Brand Name (30 day)	$50 Copay		$50 Copay
Eligible Retail 90 day maintenance	Not Applicable		90 day supply for eligible maintenance drugs at two times retail copay
Mail Order Prescription Drugs	Two times the applicable generic and brand copay for a 90-day supply		90 day supply for both eligible maintenance and non-maintenance drugs at two times retail copay
Prescription Drug Provider	BCBSM Community Blue PPO plan prescription drug benefit will be administered by CVS Caremark beginning 1/1/2014. See more information on page 35 concerning CVS Caremark.		HAP plan prescription drug benefit will continue to be administered by HAP

This comparison chart describes the essential features of the above health plans in general terms. It is not intended to be a full description of coverage. All efforts have been made to correctly summarize the level of benefits, however, if an error has been made in the summary description, the Certificate of Coverage issued by the plan will supercede this document. The complete plans are described in the Certificate of Coverage issued by each plan, and are available on request to all interested persons.

Note: Out-of-Pocket Maximum and Co-Insurance may be applied to certain services.

CVS CAREMARK PRESCRIPTION DRUG BENEFIT INFORMATION

(BCBSM Community Blue Medical Plan Participants Plan Only)

If you enroll in the BCBSM Community Blue PPO plan, your prescription drug benefit will be administered by CVS Caremark. Your prescription plan through CVS Caremark offers two ways to get your medication:

- **Retail network (short-term medications)**
  Use a CVS Caremark participating retail pharmacy when filling short-term prescriptions for medications such as antibiotics. Our network includes more than 64,000 pharmacies nationwide, including chain pharmacies, 20,000 independent pharmacies and 7,100 CVS/pharmacy stores.
- **Mail service pharmacy (long-term medications)**
  Use the CVS Caremark Mail Service Pharmacy to fill your long-term prescriptions. Mail service is a cost-effective choice for long-term medications because you can get up to a 90-day supply for less than what you would pay for the same supply at retail.

The CVS Caremark plan is a mandatory generic, mandatory mail order, step therapy and prior authorization program. For more information on these programs go to **www.mydetroitbenefits.com**

CVS Caremark FastStart can help you set up New Mail Order Service!
For more information go to www.mydetroitbenefits.com

Important Information For Mail Service Program Users

Q. What should I do if I have existing refills with another vendor?

A. Unfortunately, **CVS Caremark** is unable to access your existing refill information you will need to ask your doctor for a new prescription and mail to **CVS Caremark**. For maintenance medications, ask your doctor to write two prescriptions:

- The **first** for up to a 90-day supply plus any appropriate refills to fill through the CVS Caremark Mail Service Pharmacy. You can expect to get your prescription up to 10 days from the time your order is placed.
- The **second** for up to a 30-day supply, which you can fill at a participating retail network pharmacy to use until your mail service prescription arrives.

Q. Where do I send my prescription order?

A. All prescription orders must be submitted to CVS Caremark. Send your order and the appropriate copayment to the preprinted mailing address on the mail service order form, which is available at **www.mydetroitbenefits.com**. You will also receive a mail order form in your CVS Caremark Welcome due to arrive at your home on or before January 1, 2015. You will also receive a new mail order kit with each prescription order.

Q. How do I pay for my prescriptions?

A. CVS Caremark prefers payment by credit card, but you can also pay by check or money order. For credit card payments, include your VISA®, Discover®, MasterCard®, or American Express® number and expiration date in the space provided on the order form.

Blue Cross Blue Shield
Dental Plan Benefit Summary

Benefits	Blue Cross Dental Plan
Annual Dollar Maximum	
Maximum annual amount per covered person including diagnostic, restorative, etc.	$1,000
Diagnostic	
Oral examinations	100% (twice per year)
Emergency treatment for pain	100%
X-rays	100% limitations depending on type of x-ray)
Prophylaxis – teeth cleaning	100% twice per year)
Fluoride application	100% twice per year)
Space maintainers	100% Once per quadrant per lifetime, under age 19)
Restorative	
Fillings: Amalgam, Composite	80%
Crowns: Porcelains or Metal	50%
Endodontics	
Root canal therapy	80%
Periodontics	
Treatment for gum disease and tissue of the mouth	80%
Oral Surgery	
Extractions – simple and surgical	50%
Prosthodontics	
Complete dentures	50%
Partial dentures – chrome acrylic	50%
Fixed bridges – full cast	50%
Orthodontics	
Orthodontics (includes over age 19)	50%
Orthodontics – lifetime maximum	$1,000
Service Provider	
	For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.
	If you receive care from a nonparticipating dentist, you may be billed for the difference between our approved amount and the dentist's charge.

This comparison chart describes the essential features of the above health plans in general terms. It is not intended to be a full description of coverage. All efforts have been made to correctly summarize the level of benefits, however, if an error has been made in the summary description, the Certificate of Coverage issued by the plan will supercede this document. The complete plans are described in the Certificate of Coverage issued by each plan, and are available on request to all interested persons.

Heritage Vision Plan Benefit Summary

C.O.D. Exam and Material Benefit Frequency is once every 24 Months** (from date of last service)†

† ATU Exam and Material Benefit Frequency is once every 12 months (from date of last service)

****Progressive Myopic Children (under age 19) receive new lenses once every 12 months with a prescription change of ± .50 diopters or more.**

Covered Services	In-Network Coveragte
	In-Network Coverage is available to members at over 150 Heritage Participating Provider Locations
Comprehensive Eye Exam for Eyeglasses (Does not apply to Contact Lens Exam)	100% Covered, **No Co-Pay**
Frames	
Frames (Members have Choice of Frames)	**$100.00** Retail Allowance, **No Co-pay** (Member pays retail frame costs over $100.00)
Lenses (Per Pair): Choice of One *Covered Material = Standard Plastic CR-39*	
Single Vision	100% Covered, **No Co-Pay**
Bifocal	
Trifocal	
Lens Options and Upgrades	
Tint (One Solid Color Tint is Covered)	100% Covered, **No Co-Pay**
Scratch Resistant Coating	100% Covered, **No Co-Pay**
Prism	100% Covered, **No Co-Pay**
Frame Warranty (6 month U&C manufacturer's warranty)	100% Covered, **No Co-Pay**

OR

Contact Lenses *$90.00 Total Allowance towards: Exam, Fitting and Contact Lenses*	
Comprehensive Eye Exam for Contact Lenses[1] (Applies to Contact Lens Exam and Fitting)	**$45.00 Retail Allowance** (Member pays retail contact lens costs over $45.00)
Contacts Lenses[1] (includes disposables)	**$45.00 Retail Allowance** (Member pays retail contact lens costs over $45.00)

[1]You are eligible for contact lenses OR eyeglasses, not both, in any (24 month) Plan Year.

Exclusions (Not Covered)

- Vision Training
- Non-Prescription Lenses
- Two pairs of Glasses instead of bifocals
- Replacement of lost or broken lenses or frames
- Medical or surgical treatment of the eyes
- Services covered under Worker's Comp.

Wellness Programs for Medical Plans

Blue Cross Blue Shield of Michigan

- Living Healthy® magazine
- Weight Watchers® discount
- BlueSafe℠ for Michigan – offers discounts by showing your Blues ID card to participating retailers.
- Naturally Blue℠
- BlueHealthConnection® Good health is just a click away
  - A personalized home page called a health dashboard
  - The latest health news
  - 24 hour nurse health coach call-in
  - Online health assessment – results highly personal, 100% secure online health experience available to you 24 hours-a-day
  - Quit the Nic
  - Educational videos and books
    - Back Pain Management
    - Chronic Pain Management
    - Depression
    - High Blood Pressure
    - Women's Health
    - Men's Health
    - Prenatal Care
    - Coronary Heart Disease
    - Member outreach
  - Case management
  - Disease management
- Blue365® – BCBSM national savings program
- Healthy Bluextras℠ – exclusive savings on healthy products and services from Michigan companies at **aHealthierMichigan.org**.
- Blue Card program – across the country, around the world, we've got you covered.

Visit our web site at www.bcbsm.com for additional information

Health Alliance Plan

- Aquatics program
- HAPWise magazine
- HAP Advantage – offers money-saving discounts and extras to
- HAP members on a variety of health and wellness related activities, venues and Web sites.
- Immunization Program and Registry
- Prenatal Care Initiative
- Asthma Management program
- Anti-Coagulation comprehensive program
- Diabetes Management program
- Congestive Heart Failure program
- Depression
- High Blood Pressure program
- Smoking Cessation
- iStrive (health risk appraisal)
- Weight Watchers discount
- Global Fit discount
- Women's Health program
- Men's Health program
- Diet and Nutrition education
- Stress Management program
- Back Pain Management program
- Chronic Pain Management program Visit our web site at **www.hap.org** for additional information
- Assist America
- LifeLock through Assist America

Life Insurance Program

A group life insurance program for the employee and their dependents is available to all regular City employees on an optional basis as follows:

- **For General City Employees:** The City will pay approximately sixty percent (60%) of the premiums for insurance up to and including $12,500. The employee would pay the remaining portion of the premiums. Each dependent can be insured for $5000.
- **For Non-Civilian Employees of the Police and Fire Department:** The City will pay one hundred percent (100%) of the premiums for insurance up to and including $35,000 for the employee and $5,000 for each dependent.

Both groups of employees can purchase additional group life insurance at their own expense. Under Option 1, you can purchase an amount of life insurance approximately equal to your annual salary based upon a published schedule of salary ranges or, under Option 2, you can purchase an amount of life insurance approximately equal to twice your annual salary, based upon a published schedule of salary ranges. A change from Option 1 to Option 2 must be approved by the life insurance carrier.

The current life insurance carrier for the group life insurance available to City employees is MetLife. The toll-free number is given in this booklet.

If you wish to participate in the life insurance program, go to **www.mydetroitbenefits.com**. The amount of any required employee insurance payments will be deducted from your paycheck. You should also read the "Eligibility for Health Care and Life Insurance Benefits" section of this booklet for rules regarding dependent life insurance coverage.

City Death Benefit Program

Apart from the optional life insurance programs described above, the City has a Death Benefit program, administered by the Finance Department, which is mandatory for all regular City employees. An amount of 40¢ is automatically deducted from the employee's paycheck on a biweekly basis. (The current benefit payment on the employee's death is $10,000.)

Important Numbers

City of Detroit – Benefits Administration Customer Service

www.mydetroitbenefits.com
Toll-free (855) 224-6200

Health Carriers

Blue Cross Blue Shield Community Blue PPO..... (313) 225-0843 or 1-800-951-2583
Web site: **www.bcbsm.com**

Health Alliance Plan (HAP) ..... (313) 872-8100 or 1-800-422-4641
Web site: **www.hap.org**

Dental Carrier

BCBSM Traditional Plus ..... (313) 225-0843 or 1-800-951-2583
Web site: **www.bcbsm.com/bluedental**

Vision Carrier

Heritage Vision Plans, Membership Department 1-800-252-2053
Web site: **www.heritagevisionplans.com**

Life Insurance

MetLife Claims..... 1-800-638-6420

Flexible Spending Account

FlexPlan..... 1-800-669-FLEX (3539)

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City of Detroit Active Health Care Plans